

Certification of Health Condition

Name of Employee: _____

If providing care for a close family member, name of family member: _____

For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested shared leave.

To qualify they need to have a "severe or extraordinary illness" or injury or provide care for a close family or household member who has a "severe or extraordinary illness" or injury.

Please answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine using shared leave. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

Approximate date condition commenced: _____

Probable duration of condition: _____

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___ No ___ Yes.

If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

PART B: AMOUNT OF LEAVE NEEDED

Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee’s medical condition? ___No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from _____ through _____.

Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No ___Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? ___ No ___ Yes.

If so, explain: Based upon the patient’s medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ___ times per ___ week(s) ___ month(s)

Duration: ___ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date